NYGH and SHC
2023/24 Quality Improvement Plan

NORTH YORK GENERAL

Making a World of Difference

2023-24 NYGH QIP Indicators

NYGH Quality Dimension	Link Strategic Plan	Quality Indicator	Baseline	2023-24 Target
Timely & Effective	Drive the Future of Integrated Care – *Access and Timely Transitions of Care*	**Timely Transitions of Care:** 90th percentile Time to Inpatient Bed	33.9 Hrs. *(YTD Dec)*	24 Hrs.
Safe	Putting People First in Everything We Do – *Support Safety of our People*	**Workplace Violence Prevention:** Number of Workplace Violence Prevention Incidents that Resulted in Clinical Follow-Up	7 *(YTD Jan)*	7
		Number of Workplace Violence Incidents that Result in Lost Time	12 *(YTD Jan)*	7
	Putting People First in Everything We Do – *Support Safety of our People*	**Safe Transfer of Care:** Number of Patient Safety Events involving transfer of care where patients experience a change in team member or location	120 *(YTD Feb)*	108
Equitable & People-Centred Care	Putting People First in Everything We Do- *A culture of equity, diversity and inclusion* ** In alignment with the NYTHP strategy*	**Equitable Healthcare:** % Positive (did not encounter) response to the question: *"During your visit, did you encounter difficulties or problems for any of these categories (check any that apply)? " (e.g., Disability, Culture/Ethnicity/Race, Sexual Orientation, Language, Religion, No Issues, etc.)*	92% *(YTD Jan)*	93%
Integration and People - Centred Care	Drive the Future of Integrated Health Care - *help patients better manage their own health across the continuum*	**Integrated Health Care Experience:** Number of registered users registered on MyChart application	14,608 *(YTD Jan)*	25,000
Efficient	Investing in a Better Tomorrow – *Reduced environmental footprint*	**Efficient Use of Resources:** Reduce carbon emissions created by the hospital	8.2 kg/sf *(2022/2023)*	8 kg/sf
			182,095 kg CO2e	136,570 kg CO2e

2023-24 SHC QIP Indicators

Quality Dimension	METRIC	Baseline	2023-24 Target
Efficient	**Avoidable ED Visits:** Number of avoidable ED visits per 100 long-term care residents	18.6%	18% *CIHI Benchmark*
People -Centred	**Residence Experience:** % positive response to the question: "What number would you use to rate how well the staff listen to you?"	Collecting Baseline	Collecting Baseline
	Residence Experience: % positive response to the to the statement: "I can express my opinion without fear of consequences?"	Collecting Baseline	Collecting Baseline
Safe	**Appropriate Prescribing:** % of residents without psychosis who were given antipsychotic medication in the seven days preceding their resident assessment	25.8%	21.4% *CIHI Benchmark*
	Falls: % of long-term care residents who fell in the last 30 days	14.2%	13.8% *CIHI Benchmark*

NYGH 2023-24 QIP Workplan

Timely Transitions of Care

Goal: Improve emergency department wait time for inpatient bed

Executive Lead – Susan Woollard and Dr. Donna McRitchie

Indicator	Unit of measure/ Patient population	Data Source/Period	Baseline	Target for 2022/23	Target Justification
90th percentile Time to Inpatient Bed	Unit of Measure Hours from Disposition to admission Patient Population All patients admitted from the ED wait for an inpatient bed or an operating room	Data Source P4RHospital data; National Ambulatory Care Reporting System (NACRS); Data provided to HQO by Cancer Care Ontario Reporting Period Q3_Oct2022-Dec 2022	32.6 hrs. Q3 2022-23	24 Hrs.	• Improve upon pandemic-based performance based on last year's performance (22-23)

Change Idea	Methods	Measure	Target for Process Measures
Improve Discharge Planning Process Improve patient flow by enhancing communication methods and RMR process ***Lead:*** *Director, Medicine Program, & Manager, Care Transition*	1. RMR process: Identifying opportunities to reduce completion turnaround time 2. Build BI RMR completion rate report on portal for CTM to be reviewed on monthly basis by the program 3. Standardize RMR education process for appropriate existing and new staff	1. Percentage of RM&R submitted > 24 hours prior to ALC order; Percentage of discharge planning family meetings within 24 hours of ALC order 2. Completion date; Percentage reduction in LOS 3. Completion date; Percentage of staff completed education	1. 80% of RM&R submissions to be submitted >24 hrs prior to ALC order; 80% of discharge planning family meetings to take place with 24hrs of ALC order 2. 5% reduction by end of Q4 3. 100% of new and existing staff to complete education process by Q4
Improve ALC Length of Stay Improve turnaround time for bed placement ***Lead:****Director, Transitional Care and Community Integration & Manager, Care Transitions*	1. Reducing LTC rejections by completing Behavioral Care plans 2. Enhance model of care to improve length of stay at RCC by implementing and integrating short-term geriatric rehabilitative program for eligible patients 3. Standardize ALC data collection and improving ALC data quality through consistent documentation of ALC type and discharge destination by utilizing correct coding and flagging process	1. Percentage reduction in LTC rejections 2. Percentage reduction in LOS (TAT). Completion date; Percentage of eligible pts to go through this program 3. Percentage education and % audit confirmation of documentation accuracy	1. 5% reduction in LTC rejections by Q3 2. 100% of eligible pts to go through this program by Q4 3. 100% education and 100% audit confirmation of documentation accuracy
Patient Placement Processes Redesign patient placement reporting tools and processes to improve daily patient flow ***Lead:****Manager, Care Transitions*	1. Create and implement Patient Placement Dashboard to enhance patient placement reporting 2. Enhance non-urgent patient transportation for wheelchair discharges	1. Completion date & percentage reduction in Emergency Awaiting Admit (EAA) with red status 2. Percentage improvement in using of wheelchair discharge with non-urgent patient transportation	1. 10% reduction in EAA in red by end of Q4 2. 10% improvement by end of Q4

Workplace Violence Prevention

Goal: Reduce overall number of incidents of workplace violence

Executive Lead – Mitch Birken

Indicator	Unit of measure/ Patient population	Baseline	Target for 2022/23	Target Justification
Number of Workplace Violence Prevention Incidents that Resulted in Clinical Follow-Up	Unit of Measure: Incidents Reporting Period: Jan 2021-Dec 2021 Population: All staff with an WV incident	7 incidents (Jan YTD)	7 incidents	Maintain previous year target
Number of Workplace Violence Incidents that Result in Lost Time	Unit of Measure: Incidents Reporting Period: Jan 2021-Dec 2021 Population: All staff with an WV incident	12 incidents (Jan YTD)	7 incidents	Maintain previous year target

Change Idea	Methods	Measure	Target for Process Measures
Education and Awareness Initiatives • Implement Mandatory Crisis Intervention Training for Newly Hired Staff. • Implement education related to verbal abuse and harassment interventions with a focus on situations including visitors ***Lead:*** *Director, IPAC and Occupational Health and Director, Mental Health*	• Implement a standardized scheduling process for in-person crisis intervention training for all newly hired staff and existing staff. • Develop a standardized process for leaders to use when managing incidents involving a visitor who has been engaged in threatening, racist or discriminatory behaviours.	• Percentage of staff signed up and trained in Crisis Intervention. • Number of presentations to the Leadership Management Team (LMT) on the escalation process.	• 90% of available spots for in-class training to be filled and 90% of scheduled staff to attend in-class Crisis Intervention Training by March 31, 2024. • 1 presentation to the Leadership Management Team (LMT) on the escalation process by Q4.
Increase Care Plans for Patients with Potential to Harm Behaviour • Sustain the process of creating a care plan for patients who have been identified with a behavioural alert (Danger to other) ***Lead:*** *Clinical Nurse Educator, Mental Health Program*	• Initiate and develop a WPV care plan(cross-encounter) for patients flagged/alerted by ED TOA. • Develop a standardized process to initiate a WPV care plan for patients who had at least one security assist or code white called during current hospitalization.	• Percentage of WPV care plan (cross-encounter) initiated for patients flagged/alerted by ED TOA. • Percentage of WPV care plans are initiated for patients who had at least one security assist or code white called during current hospitalization.	• 80% of WPV care plan (cross-encounter) must be initiated for patients flagged/alerted by ED TOA. • 100% of patients who had at least one security assist or code white called during current hospitalization to have a WPV care plan.
Develop a Sustainable Code White Simulation Program • Build capacity to conduct Code White simulations in areas with a high number of Code White Calls. Continue with Code White Simulations for members of the Code White Team. ***Lead:*** *Director, Mental Health*	• Standardize the process for units to request a Code White Simulation in their clinical area. • Collaborate with Simulation Manager to develop a point-of-care facilitator model.	• The completion date and the number of education sessions for the leadership team (LMT, CTM, and CNEs). • Total Number of simulations completed on the requested units & number of staff facilitators trained to develop Code White Simulators.	• Standardized process to be developed by Q2 and 2 education sessions to be completed by Q3. • Minimum 2 Code White Simulation to be completed on requested units by Q4 & Train 2 staff from Mental Health to be the point of care code white facilitators by Q4.

Safe Transfer of Care

Goal: Reduce overall number of patient safety incidents related to transfer of accountability (TOA)

Executive Lead – Susan Woollard

Indicator	Unit of measure/ Patient population	Baseline	Target for 2022/23	Target Justification
Number of Patient Safety Events involving transfer of care where patients experience a change in team member or location	Unit of Measure: Incidents Reporting Period: Apr 2022-Mar 2023 Population: all patients	120 YTD (Feb 2023)	108	10% reduction-The focus will be to implement policies and processes to mitigate any safety events related to transfer of care where patients experience a change in team member or location

Change Idea	Methods	Measure	Target for Process Measures
Improve Safety of Inpatient Transport Improve patient safety during transport by developing standardized processes ***Lead:*** *Director, Medicine Program*	• Conduct a current state analysis to understand and identify gaps in patient transfer processes in all clinical areas • Revamp *Ticket to Ride* initiative in applicable units as required • Develop Standard Work for clerical and portering staff	• Completion Date • Number of units with *Ticket to Ride* initiative as patient transfer process • Percentage of clerical and portering staff trained	• Completed by end of Q1 2023-24 • All identified units to use *Ticket to Ride* process for safe patient transport by Q4 • 100% of clerical and portering staff to be trained by Q4
Standardize Transfer of Care Policies and Procedures Develop and implement a consistent approach to patient transport across the organization ***Lead:*** *Director, Professional Practice*	• Revise Transfer of Accountability Policy & Procedure • Develop patient inclusion and exclusion criteria with professional practice leads and nurse educators to include in the policy & procedure • Provide education and on-site support across sites on the new Transfer of Accountability Policy & Procedure	• Completion Date • Completion Date • Percentage of staff received transfer of accountability education	• Policy to be revised by Q2 • Develop the inclusion and exclusion criteria by Q2 • 100% of staff to receive the education by end Q4

Equitable Healthcare

Goal: Foster a safe, inclusive environment where everyone feels welcomed, respected and valued

Executive Lead – Susan Woollard and Mitch Birken

Indicator	Unit of measure/ Patient population	Data Source/Period	Baseline	Target for 2022/23	Target Justification
% respondents who responded positively (did not encounter) to the question: *"During your visit, did you encounter difficulties or problems for any of these categories (check any that apply)? " (e.g., Disability, Culture/Ethnicity/Race, Sexual Orientation, Language, Religion, No Issues, etc.)*	Unit of Measure Percentage Patient Population All survey respondents	Data Source Patient Experience Phone Surveys, Patient Experience Survey determined by OHA and Internal surveys Reporting Period Arp 2022-Mar 2023	92% (YTD Feb)	93%	While the ideal target is 100% of patients not to encounter any discrimination during their visit, a realistic approach was taken for setting the target. The focus will be to advance our equity agenda and create impactful change initiatives to strive to 100%

Changes	Methods	Measure	Target for Process Measure
Advancing Equity, Diversity and Inclusion Framework Provide education and build capacity for EDI amongst staff, physicians, learners and volunteers ***Lead:*** *Manager, Equity, Diversity and Inclusion*	Providing educational and information sessions on: • Racial micro aggression • Islamophobia and inclusion from Muslim employees • Antisemitism and inclusion for Jewish employees • Appropriate use of pronouns • Conducting focus groups to deepened our understanding of anti-black racism survey results and action planning to address anti-black racism • Adding pronouns to staff ID badges to be inclusive of people of all genders • Work with Corporate Communication to ensure NYGH website accessibility compliance (WCAG 2.0)	1. Percentage of staff attended the sessions 2. Completion date 3. Implementation date 4. Completion date	1. 25% of staff to receive training on racial micro aggression by March 31st, 2024; 3% staff to attend other educational sessions by March 31, 2024 2. By December 31, 2023 3. Complete implementation by December 31st, 2023 4. By end of March 31, 2024
Onboard and Engage Patient Experience Partners in their New Role Advance the NYGH People Centred Care strategy and its commitment to involving more volunteers and input from diverse religious, cultural and economic backgrounds. ***Lead:*** *PCC Consultant and Director, Quality, PCC and Care Transitions*	• Create orientation and onboarding materials and transition new Patient Experience Partners into the organization • Provide professional development and engagement sessions to foster PXP growth and equip patient partners with knowledge to be successful in their role • Partner PXPs with hospital programs and initiatives based on their professional expertise and lived healthcare experience	1. Completion date 2. Number of sessions held 3. Percentage of PXPs appropriately matched to a program	1. Onboarding and orientation materials to be created by Q2 2. 12 sessions to be held by end of Q4 3. 100% of PXPs to be matched to an appropriate program by end of Q2
Advancing Equity Data Collection Develop a consistent approach for equity, diversity and inclusion including data collection methods across NYTHP ***Lead:****Director, OHT and Transformation and TBD Lead for Data collection*	• Survey OHT Partners to gain a better understanding of current state of collecting patients' sociodemographic data and identifying improvement opportunities • Create Measuring Health Equity in Toronto Region Implementation Workplan	1. Survey completion date 2. Completion date	1. Complete the survey, analyze the results and identify opportunities by end of Q2 2. Workplan to be created by end of Q2

Integrated People -Centred Care

Goal: Increase number of patients using MyChart application

Executive Lead – Young Lee

Indicator	Unit of measure/ Patient population	Data Source/Period	Baseline	Target for 2022/23	Target Justification
Number of registered users on MyChart application	Unit of Measure Number Patient Population All NYGH MyChart users	Data Source Hospital internal data collection Reporting Period March 2020 to March 2023	15,022 (YTD Feb)	25,000	Since launch in March 2020, MyChart has seen an average of 350 users added per month. Our target is to increase the number of users that register for the service and complete registration to become active Users.

Changes	Methods	Measure	Target for Process Measure
Improve access to health information within MyChart Leverage the full functionality available in MyChart to provide patients access to more of their NYGH health record ***Lead:*** *Chief Digital Officer and Information Services*	• Improve access to data within Mychart by improving adoption of online documentation in the ED	• Number of Emergency Department reports accessed in MyChart	• 5% increase from baseline in reports accessed through ED
Increase adoption of the My Chart application Build promotional materials and information sessions to increase awareness for existing patients and add more mechanisms to register to broaden reach of MyChart for new and existing patients. ***Lead:*** *Chief Digital Officer and Information Services*	• Develop a process to collect consent for MyChart access and email address at the main registration and check-in • Increase awareness through promotional materials made available on patient care units and public spaces at all three campuses.	• Completion date • Percentage of registered and active users	• Process to be completed by end of Q4 • 5% growth in number of registered users and 5% growth in number of active users by Q4
Collecting Email Addresses Develop an approach for collecting email addresses to improve patient experience data collection ***Lead:*** *Director, Quality, PCC and Care Transitions*	• Establish a working group to evaluate different methods and create a workplan • Implement policies, SOP and guidelines for the collection of email addresses in Cerner	• Completion date • Completion date	• Establish working group by end of Q2 • Develop policies, SOPs and guidelines by end of Q4

Efficient Use of Resources

Goal: Improve environmental sustainability through the efficient use of resources

Executive Lead – Rudy Dahdal

Indicator	Unit of measure/ Patient population	Data Source/Period	Baseline	Target for 2022/23	Target Justification
Percentage reduction in carbon emissions	Kilograms/square foot of hospital area **Population:** Population	2018 calendar year energy use which is the baseline for the 2019 Energy Conservation and Demand Management (ECDM) Plan **Data Source:** In house data collection **Period:** April 2022 to March 2023	8.2 kg/sf (2022/2023)	8 kg/sf	Improve based on last year's performance
Percentage reduction in carbon emissions	Kilograms CO2e **Population:** Population	Materials Management, Plastic Bag Use By Unit Data, 2021/22 **Data Source:** In house data collection **Period:** April 2022 to March 2023	182,095 kg CO2e	136,570 kg CO2e	25% reduction of CO2e, based on equivalent reduction of plastic bags

Changes	Methods	Measure	Target for Process Measures
Retrofit Projects to Reduce Carbon Emissions ***Lead:*** *Director, Facilities and Support Services*	• Complete feasibility studies on identified projects and implement natural gas (m3) & electricity (kWh) savings projects based on the feasibility and cost saving	• Number of projects completed and GHG (kg/sf) saving achieved per project	• Implement and complete 4 projects by end of Q4 to meet 8kg/sf
Advancing NYGH's Sustainability Agenda ***Lead:*** *Director, Capital Planning Clinical Leader, TBD*	• Implement "Bring Your Own Reusable Bag" (BYORB) sustainability initiative across organization, starting in targeted programs with high plastic bag usage.	• Percentage reduction in Plastic Bags usage	• 25% reduction in total number of plastic bags across organization by Q4.

SHC 2023-24 QIP Workplan

Avoidable ED Visits

Executive Lead – Susan Woollard

Goal: Reduce (lower) Potentially avoidable emergency department visits for long-term care resident

Indicator	Unit of measure/ Patient population	Baseline	Target for 2022/23	Target Justification
Number of ED visits for a modified list of ambulatory care-sensitive conditions* per 100 long-term care residents.	**Unit of Measure:** rate per 100 residents **Population:** LTC home residents **Data Source:** CIHI CCRS, CIHI NACRS **Period:** October 2021-September 2022	18.6% Current performance populated by HQO=**19.26**	18.0%	Target was set based on CIHI benchmark data (Provincial rate is currently 18.5; Central LHIN is 21.3 – we are performing lower than our LHIN)

Change Idea	Methods	Measure	Target for Process Measure
Goal of Care Planning and the Resident Health Care Wishes assessment will be completed within 6 weeks of a resident's admission	Goals of care will be discussed and documented on the resident chart within 6-8 weeks of interdisciplinary care conference	1. Percentage of new admissions (within 6-8 weeks,) with completed "Goals of Care" care planning 2. Percentage of new admissions (within 6-8 weeks) with completed "Resident Health Care Wishes" assessments.	1. 100% completion rate every 6-8 weeks for appropriate residents 2. 100% completion rate every 6-8 weeks for applicable residents
Call to the NP or MD before sending resident to the ED to get their professional opinion on whether the resident can be treated within the home	Call will be made to the NP or MD to discuss resident condition before sending out (except in the case of emergency)	1. Percentage of residents with a call before being transferred to the hospital (excluding emergency cases)	1. 100 % of residents transferred to hospital (excluding emergency cases) will have an order

Resident Experience: Having a voice

Goal: Improve the resident experience

Executive Lead – Susan Woollard

Indicator	Unit of measure/ Patient population	Baseline	Target for 2022/23	Target Justification
Percentage of residents who responded positively to the question: *"What number would you use to rate how well the staff listen to you?"*	**Unit of Measure:** Percentage **Population:** All LTC residents **Data Source:** In house data collection **Period:** Annual Resident Satisfaction Survey	Collecting Baseline	Collecting Baseline	This is the first year for this indicator. This indicator was added in alignment to OH guidance. The question will be added to our patient survey to collect data .

Change Idea	Methods	Measure	Target for Process Measure
Actively involve the residents in performance reviews of the staff	Each resident capable of participating will be asked a question about the staff that care for them	1. Number of performance reviews held & percentage feedback shared with staff	1. 12 performance reviews to be held by Q4;100% of feedback from the resident will be shared with the staff member
Member of the Leadership Team to meet with resident group monthly with invitation	Each month a meeting will be held with a member of the Leadership Team when invited	1. Number of meetings held with a member of Leadership Team for residents to provide areas for improvements in the home & percentage of concerns addressed	1. 3 meetings to be held by Q4; 100% of concerns or opportunities brought forward will be addressed and followed up with

Resident Experience: Being able to speak up about the home

Executive Lead – Susan Woollard

Goal: Improve the resident experience

Indicator	Unit of measure/ Patient population	Baseline	Target for 2022/23	Target Justification
Percentageof residents who responded positively to the following statement: *"I can express my opinion without fear of consequences?"*	**Unit of Measure:** Percentage **Population:** All LTC residents **Data Source:** In house data collection/inteRAL survey **Period:** Annual Resident Satisfaction Survey	Collecting Baseline	Collecting Baseline	This is the first year for this indicator and we will be collecting baseline data

Change Idea	Methods	Measure	Target for Process Measure
Actively involve the residents in performance reviews of the staff	Each resident capable of participating will be asked a question about the staff that care for them	1. Number of performance reviews and percentage of shared feedback with staff	1. 12 performance reviews to be held by Q4;100% of feedback from the resident will be shared with the staff member
Member of the Leadership Team to meet with resident group monthly with invitation	Each month a meeting will be held with a member of the Leadership Team when invited	1. Number of meetings held with a member of Leadership Team for residents to provide areas for improvements in the home & percentage of concerns addressed	1. 3 meetings to be held by Q4; 100% of concerns or opportunities brought forward will be addressed and followed up with

Appropriate Prescribing

Executive Lead – Susan Woollard

Goal: Reduce number of inappropriate antipsychotic use in long-term care

Indicator	Unit of measure/ Patient population	Baseline	Target for 2022/23	Target Justification
Percentage of LTC home residents without psychosis who were given antipsychotic medication in the seven days preceding their resident assessment	**Unit of Measure:** Percentage **Population:** All LTC residents with a valid RAI-MDS assessment **Data Source:** Continuing Care Reporting System (CCRS), Integrated interrail Reporting System (IRRS). CIHI via CCRS eReports **Period:** 2023-24/rolling four quarter avg	25.8% **21.68** *(data prepopulated by HQO)* Q2 2022-23 (July 2022-Sep 2022)	21.4%	Target was set based on CIHI Ontario benchmark data.

Change Idea	Methods	Measure	Target for process Measure
Pharmacist and MRP to work collaboratively to review each resident on an antipsychotic without a diagnosis	1. Pharmacist will work with the MDs to review all residents using antipsychotics	1. Percentage of resident medication reviewed with a decrease in dose/or actual discontinuation of medication	1. 100% of residents reviewed, will have a decrease or discontinuation
Pharmacist to provide monthly progress audits	1. Pharmacist to complete audits of all residents on an antipsychotic	1. Number of audits completed per month	1. Minimum of 5 audits per month to be completed.
Gentle Persuasive Approach	1. SHC will increase the number of staff with GPA Training	1. Percentage of staff participating in GPA training	1. 10% of staff on all shifts will have GPA Training by December 31, 2023

Falls

Executive Lead – Susan Woollard

Goal: Reduce number of falls

Indicator	Unit of measure/ Patient population	Baseline	Target for 2022/23	Target Justification
Percentage of long-term care home residents who fell during the 30 days preceding their resident assessment.	**Unit of Measure:** Percentage **Population:** All LTC residents **Data Source:** Continuing Care Reporting System (CCRS), CIHI **Period:** 2022-2022/reported quarterly	14.2% *Reported: Quarterly*	13.8%	Target was set based on CIHI benchmark data.

Change Idea	Methods	Measure	Target for process Measure
Minimize risk of injury associated with falls	1. Ensure all residents have fall prevention equipment 2. Ensure all residents have a fall's focus in their Plan of Care, using an interdisciplinary approach	1. Percentage of residents with fall prevention equipment 2. Percentage of residence with a fall's focus in their Plan of Care using an interdisciplinary approach	1. 100% of residents who have fallen/identified at risk of falling to have appropriate fall prevention equipment by Q4 2. 100% of residents who have fallen/identified at risk of falling to have a fall's focus in their Plan of Care by Q4
Identify high risk residents and implement appropriate inventions within 14 days of admission	1. Completion of "Falls Risk Assessment" on day of admission.	1. Percentage of documented care plans focused on "Risk of Falls" on admission day for high-risk residents	1. 100% of high-risk residents to have care plans focused on "Risk of Falls" within 14 days of admission
High Risk Falls huddles to take place with staff post fall	1. Ensure all residents who have fallen have a documented falls huddle	1. Number of falls huddles matching the number of falls	1. All of residents that have fallen have had a falls huddle documented